Appendix B - Rural Needs Impact Assessment (RNIA) Template

SECTION 1 - Defining the activity subject to Section 1(1) of the Rural Needs Act (NI) 2016

1A. Name of Public Authority.

Public Health Agency

1B. Please provide a short title which describes the activity being undertaken by the PHA that is subject to Section 1(1) of the Rural Needs Act (NI) 2016.

Change to the service delivery model of the Northern Ireland Diabetic Eye Screening Programme (NIDESP).

1C. Please indicate which category the activity specified in Section 1B above relates to.

Developing a	Policy	☐	Strategy	☐	Plan	☐
Adopting a	Policy	☐	Strategy	☐	Plan	☐
Implementing a	Policy	☐	Strategy	☐	Plan	☐
Revising a	Policy	☐	Strategy	☐	Plan	☐
Designing a Public Service		☐				
Delivering a Public Service		☐				

1D. Please provide the official title (if any) of the Policy, Strategy, Plan or Public Service document or initiative relating to the category indicated in Section 1C above.

Consultation on the way the Northern Ireland Diabetic Eye Screening Programme is provided.

1E. Please provide details of the aims and/or objectives of the Policy, Strategy, Plan or Public Service.

The Northern Ireland Diabetic Eye Screening Programme (NIDESP) aims to reduce visual morbidity caused by diabetic eye disease by facilitating early diagnosis and treatment of sight-threatening retinal disease through population screening. The programme is provided by the Belfast HSC Trust and in 2016/17 there were over 91,000 people registered with the programme living with diabetes over the age of 12.

This is a significant increase from the approximately 50,000 at the start of the programme and the eligible population is expected to increase as the number of people with diabetes continues to rise (currently by 5% per year). By 2020/21 it is expected that 108,000 people a year will be eligible for diabetic eye screening.

The NIDESP has been undergoing a multi-phase modernisation programme, phase 2b of which is to review the way in which the programme is delivered. The current model is mixed, with 6 fixed sites in the western trust area and a peripatetic service provided at GP practices within all other areas. This mobile model is no longer sustainable and has been coming under increasing pressure, primarily due to the considerable increase in the eligible population and a number of issues in terms of quality and logistics. The number of people living with diabetes in Northern Ireland has almost doubled in the last decade increasing the challenges faced by the programme.

One of the key drivers for change is the inability to maintain the screening interval (at 12 months +/- 6 weeks). The average interval is normally longer and can be up to 18 months, or more, for some practices. There can be multiple reasons for this including;

- The mobile model requires practices to provide a room in their premises for a set number of days during a specific period of time. This can prove very challenging for practices, particularly given the growth of the eligible screening population, meaning that rooms are required for longer. This impacts other work in the practice.
- The screening technicians operate as lone workers and there are potential issues with staff satisfaction, with clinics being vulnerable to cancellation if a technician is unavailable.

A change to a fit for purpose service delivery model will allow the programme to meet national QA standards, including meeting the 12 month screening interval, and will reduce pressure on GP practices. It will also allow the invitation method to change to individual based rather than GP practice based and this in turn will provide suitable conditions for the introduction of the variable screening interval. This variable screening interval is a recommendation of the National Screening Committee, which would see those at lower risk of retinopathy being screened every two years, with those at high risk remaining at the 12 month interval.
The consultation is seeking views on the 3 remaining options following an options appraisal process and previous pre-consultation. The remaining shortlisted options are as follows;

Option 2a – regional fixed location service provided at HSC locations, e.g. local hospitals, community hospitals, health and wellbeing centres, and suitable GP practices
Option 2b – regional fixed location service provided at individual GP surgeries
Option 5 – High-street optometry based service provided at community optometrists' premises

The preferred model is option 2a which would allow the programme to address the drivers for change. A regional fixed site model would ensure that suitable rooms are available when required and enable the addition of visual acuity testing to the screening programme. Those invited would have a choice of venue to attend for screening and could, for example, select the nearest site to their home, or place of work. Anyone who cannot attend their screening appointment would be able to reschedule at a suitable venue, rather than being restricted to 'mop up' clinics in Belfast venues. Invites would be by individual rather than being based on the participant's GP practice.

1F. What definition of 'rural' is the PHA using in respect of the Policy, Strategy, Plan or Public Service?

Population Settlements of less than 5,000 (Default definition). ☐

Other Definition (Provide details and the rationale below). ☐

A definition of 'rural' is not applicable. ☐

Details of alternative definition of 'rural' used.

Rationale for using alternative definition of 'rural'.

Reasons why a definition of 'rural' is not applicable.

SECTION 2 - Understanding the impact of the Policy, Strategy, Plan or Public Service

2A. Is the Policy, Strategy, Plan or Public Service likely to impact on people in rural areas?

Yes ☐ No ☐ If the response is **NO** GO TO Section **2E**.

2B. Please explain how the Policy, Strategy, Plan or Public Service is likely to impact on people in rural areas.

The proposed model options will reduce the number of screening sites from around 280 GP practices in the Belfast, South Eastern, Northern and Southern trust areas to an estimated:

- Minimum of 22 sites across Northern Ireland (including the western area where the 6 established fixed sites would remain)
- 60 high street optometry practices across Northern Ireland (including the western area)

There is the potential for increased travel time and distance for those in urban and rural areas, particularly for those outside the western area (who are already travelling to fixed sites) to attend screening appointments. The exact impact upon people in rural areas cannot be defined until potential sites are ascertained or until it is clear which optometry practices could, would wish to, provide screening.

2C. If the Policy, Strategy, Plan or Public Service is likely to impact on people in rural areas *differently* from people in urban areas, please explain how it is likely to impact on people in rural areas differently.

The key impact on rural areas of a change to the service delivery model will be the increased need to travel, whilst this will impact on both urban and rural communities the barriers may be greater for those in rural areas due to increased drive times and poorer public transport provisions.

2D. Please indicate which of the following rural policy areas the Policy, Strategy, Plan or Public Service is likely to primarily impact on.

Rural Businesses	☐
Rural Tourism	☐
Rural Housing	☐
Jobs or Employment in Rural Areas	☐
Education or Training in Rural Areas	☐
Broadband or Mobile Communications in Rural Areas	☐
Transport Services or Infrastructure in Rural Areas	☐
Health or Social Care Services in Rural Areas	☐
Poverty in Rural Areas	☐
Deprivation in Rural Areas	☐
Rural Crime or Community Safety	☐
Rural Development	☐
Agri-Environment	☐
Other (Please state)	

If the response to Section 2A was YES GO TO Section 3A.

2E. Please explain why the Policy, Strategy, Plan or Public Service is NOT likely to impact on people in rural areas.

N/A

SECTION 3 - Identifying the Social and Economic Needs of Persons in Rural Areas

3A. Has the PHA taken steps to identify the social and economic needs of people in rural areas that are relevant to the Policy, Strategy, Plan or Public Service?

Yes ☐ No ☐ If the response is **NO** GO TO Section **3E**.

3B. Please indicate which of the following methods or information sources were used by the PHA to identify the social and economic needs of people in rural areas.

Consultation with Rural Stakeholders	☐	Published Statistics	☐
Consultation with Other Organisations	☐	Research Papers	☐
Surveys or Questionnaires	☐	Other Publications	☐
Other Methods or Information Sources (include details in Question 3C below).			☐

3C. Please provide details of the methods and information sources used to identify the social and economic needs of people in rural areas including relevant dates, names of organisations, titles of publications, website references, details of surveys or consultations undertaken etc.

A pre-consultation exercise was carried out from 1st October to 31st December 2017. The pre-consultation documentation described the advantages, and disadvantages, of each option and listed the objectives, including weightings, that would be used to assess these options in the option appraisal. The accompanying questionnaire sought opinion on the completeness and suitability of the same and also further information on equality and rurality implications. Respondents were asked to consider if there were implications for rural areas which the programme needed to consider. A total of 39 responses were received. The majority of responses were from high street optometrists and members of the public/service users.

Stakeholder engagement was also carried out during the 12 week pre-consultation period. Screening staff from the Public Health Agency attended multiple stakeholder events and presented on the purpose of the pre-

consultation and the aims of the modernisation project (see **Appendix 5** of the consultation paper for further details). Presentations were made to several key groups including to the Primary Care Diabetes Society, each of the five Local Commissioning Groups, the Optometrists NI board, and the Northern Ireland General Practitioner Committee.

The pre-consultation document and accompanying response questionnaire was also widely distributed to users attending screening/Hospital Eye Services clinics, workstreams of the Diabetes Network, user representatives within Diabetes UK (NI) and was published on the PHA website.

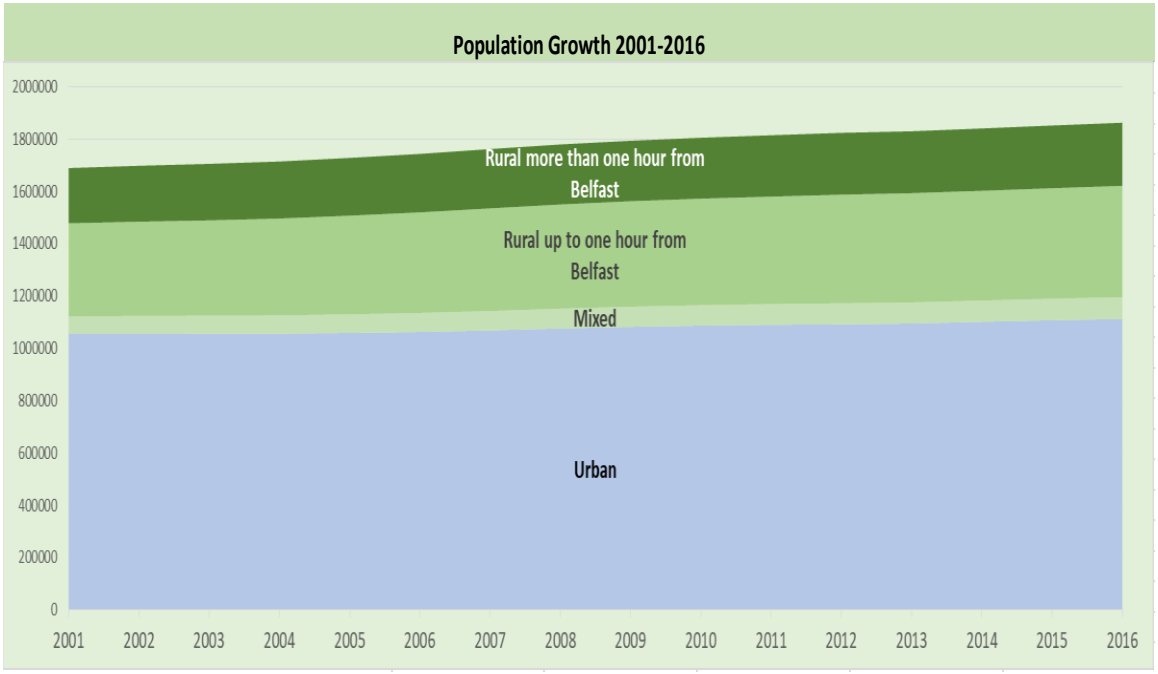
In addition to the pre-consultation exercise, page 16 details the methods and information sources that were used to assess the potential impact of the change to the service delivery model.

The programme plans to engage further during the consultation period with rural stakeholders, for example, identifying suitable forums through Diabetes UK(NI), RNIB and the Diabetes Network.

3D. Please provide details of the social and economic needs of people in rural areas which have been identified by the PHA?

According to the 2011 census, in Northern Ireland around 640,000 people live in rural areas, this equates to 36% of the population. Recently mid-year estimates by NISRA suggest that there has been some growth in rural populations during the period 2001-2016 from 34% to 36% (Figure 1).

Figure 1 – Mid Year Population Growth Estimates 2011 - 2016



	Population 2001	Proportion of total population	Population 2016	Proportion of total population	Population growth 2001-2016
Urban	1056415	63%	1112338	60%	5%
Mixed	65593	4%	83315	4%	27%
Rural <= 1 hour from Belfast	355642	21%	425265	23%	20%
Rural > 1 hour from Belfast	211185	13%	241232	13%	14%
Rural within 20 minutes of a settlement of 10,000 or more	337616	20%	396049	21%	17%
Rural outside 20 mins of a settlement of 10,000 or more	229211	14%	270448	15%	18%
All rural	566827	34%	666497	36%	18%
All NI	1688835	100%	1862150	100%	10%

Source: Northern Ireland Mid-Year Population Estimates 2016 at Small Area Level, Northern Ireland Statistics and Research Agency, November, 2017
https://www.nisra.gov.uk/publications/2016-mid-year-population-estimates-northern-ireland

Transport

The vast majority (93%) of the Northern Ireland population live within 30 minutes' drive-time of a large service centre (a settlement of 10,000 people or more), with 80% living within 20 minutes' drive-time[1]. Whilst 23% of households in Northern Ireland have no access to a car, in rural areas this drops to 12%, compared to 29% in urban areas[2]. The figure for no access to a car rises to 53% of 1 person households age 65 years or older. This would suggest a more significant impact on older people if screening sites are not accessible by public transport.

[1] Department of Agriculture, Environment and Rural Affairs. A Guide to the Rural Needs Act(NI) 2016 for Public Authorities (Revised April 2018)
[2] Northern Ireland Statistics and Research Agency. Northern Ireland Census 2011, Table 405.

Figure 2 – Availability of car or van (all households)

	No cars or vans	1 car or van	2 cars or vans	3 or more cars or vans	Total
Mixed urban/rural	11%	40%	36%	13%	28845
All rural	12%	37%	36%	15%	227949
Rural <=20 mins from settlement[1]	11%	37%	36%	15%	137441
Rural >20 mins from settlement[1]	13%	37%	35%	16%	90508
Rural <= 1 hour from Belfast	10%	37%	37%	16%	145650
Rural > 1 hour from Belfast	14%	38%	33%	14%	82299
Urban	29%	44%	22%	5%	446481
All	23%	41%	27%	9%	703275

Source: Census Key Statistics for Small Areas Table 405

1. Settlement with a population of 10,000 or more

People in rural areas have further to travel to access public transport (figures 3 and 4), with less frequent services and further distance to travel.

Figure 3 - Time taken to walk to nearest bus stop 2014-2016

Time taken	Percentage of households		
	Urban areas	Rural Areas	All Northern Ireland
3 minutes or less	41%	22%	34%
4-6 minutes	39%	23%	33%
7-13 minutes	15%	19%	16%
14-26 minutes	5%	18%	10%
27-43 minutes	0%	8%	3%
44 mins or longer	0%	9%	4%

Figure 4 Time taken to walk to nearest NI Railways station 2014-2016

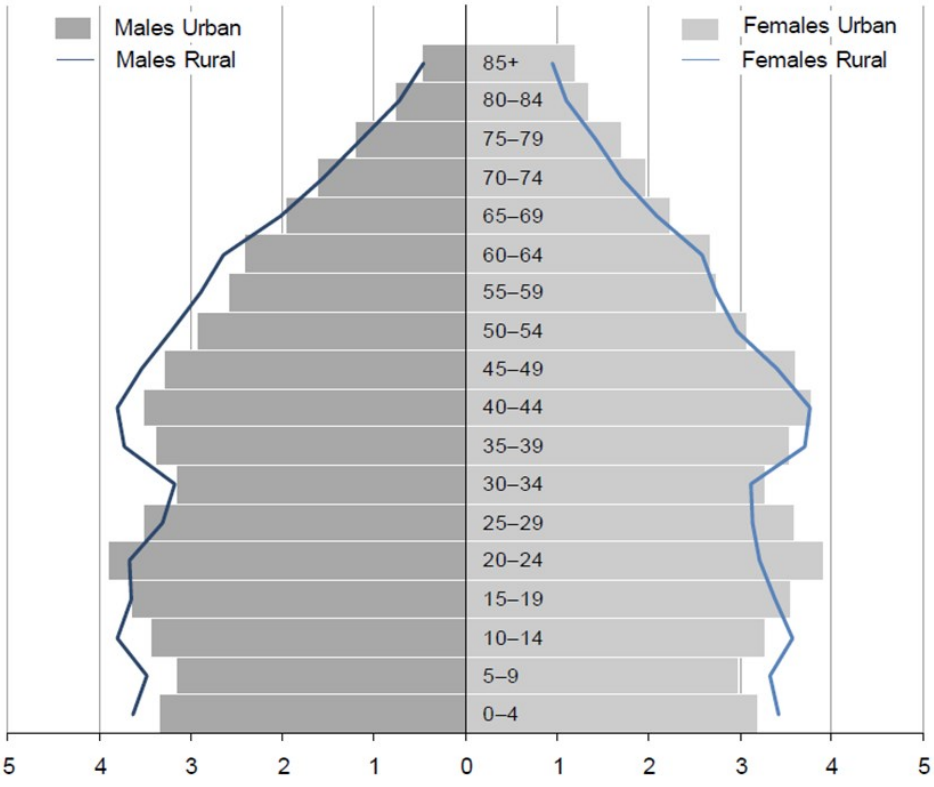
Time taken	Percentage of households		
	Urban areas	Rural Areas	All Northern Ireland
6 minutes or less	5%	1%	4%
7-13 minutes	9%	1%	6%
14-26 minutes	24%	3%	17%
27-43 minutes	18%	5%	14%
44 minutes or longer or not applicable	43%	91%	60%

Source: Travel Survey 2014-2016

Age

The age profile of rural and urban areas in Northern Ireland is relatively similar, with some exceptions, for example rural areas have higher proportions of children (aged 0 to 14), and lower levels of women aged 45 and over[3]. An estimated 39% of pensioners in Northern Ireland live in rural areas[4].

Figure 4 – Population Pyramid for Northern Ireland (by area type, mid-2008)



Source: Northern Ireland Statistics and Research Agency

Health

This service delivery change will primarily affect service users who have received a diagnosis of diabetes. Published data on the urban/rural distribution of people living with diabetes in Northern Ireland is not available, however we can look at some of the risk factors and complications of

[3] Office for National Statistics. Rural and urban areas: comparing lives using rural/urban classifications 2010/11. Tim Pateman

[4] Northern Ireland Assembly, Key Health Issues Affecting Rural Communities. 2010

diabetes to gain a better understanding of the degree of impact within these communities.

One of the key risk factors for the development of type 2 diabetes is obesity, whilst there are no population wide statistics on the obesity levels in urban and rural areas, sample based figures produced by the Department of Health[1] showed that during the period 2010/11 to 2016/17 the levels of adults classified as obese were slightly higher in rural areas, with the exception of 2012/13 and 2015/16[5].

There are higher rates of disability amongst those living with diabetes, with increased rates of comorbidities and potential complications from diabetes. Across Northern Ireland an estimated 21% of the population has a disability, this is measured by the number of people reporting that a long term condition or disability limits their day to day activities, the table below shows slight differences between rural and urban areas, this difference is more pronounced in the largest settlement areas, Belfast and Derry, where reported levels were 24%.

Figure 5 – Long term health problems (all persons)

	Daily activities limited a lot	Daily activities limited a little	Daily activities not limited	Total
Mixed urban/rural	10%	8%	82%	79052
All rural	10%	8%	81%	644087
Rural <=20 mins from settlement[1]	10%	8%	82%	383224
Rural >20 mins from settlement[1]	11%	9%	81%	260863
Rural<=1 hour from Belfast	10%	8%	82%	410184
Rural> 1 hour from Belfast	11%	9%	80%	233903
Urban	13%	9%	78%	1087724
All	12%	9%	79%	1810863

Source Census Key Statistics for Small Areas Table 301

1. Settlement with a population of 10,000 or more

Dependent Status

Given their older age profile, it may be reasonable to assume that fewer people living with diabetes will have young dependents than in the general population as a whole, however they may, for example, care for grandchildren. It is also recognised that some older people will themselves be carers, as Age UK data (2013) underlines: in the UK nearly 50,000 people

[5] Department of Health. Making Life Better – Key Indicators Progress Update Tables 2018.

aged over 85 provide unpaid care to a partner, family member or other person

In 2012, the Carers Trust estimated that around 49,000 carers in Northern Ireland were over the age of 60. Conversely, younger people with diabetes will be more likely to have caring responsibilities, including for children and/or older dependents. Figure 6 below shows the rates of caring responsibilities in urban and rural areas according to the Continuous Household Survey, which randomly samples 4,500 households in Northern Ireland each year. Whilst these results are based on a sample of households they show very little difference in levels of caring responsibilities across urban and rural communities.

Figure 6 – Caring Responsibilities 2016/17 in Urban and Rural Areas

Caring responsibilities, 2016/17					
	Responsibility for care of child	**Responsibility for care of person with a disability**	**Responsibility for care of elderly person**	**Average number of persons cared for by carers**	**Base=100 %**
All urban	33%	11%	10%	1.8	2145
Rural <=20 mins from settlement[1]	34%	11%	9%	1.9	640
Rural >20 mins from settlement[1]	30%	10%	9%	1.9	473
Rural <=60mins from Belfast	34%	11%	10%	1.9	699
Rural >60mins from Belfast	30%	10%	7%	1.9	414
All rural	33%	11%	9%	1.9	1113
Total	**33%**	**11%**	**10%**	**1.9**	**3258**

1. Settlement with a population of 10,000 or more
Source Continuous Household Survey 2016/17

Availability of Services

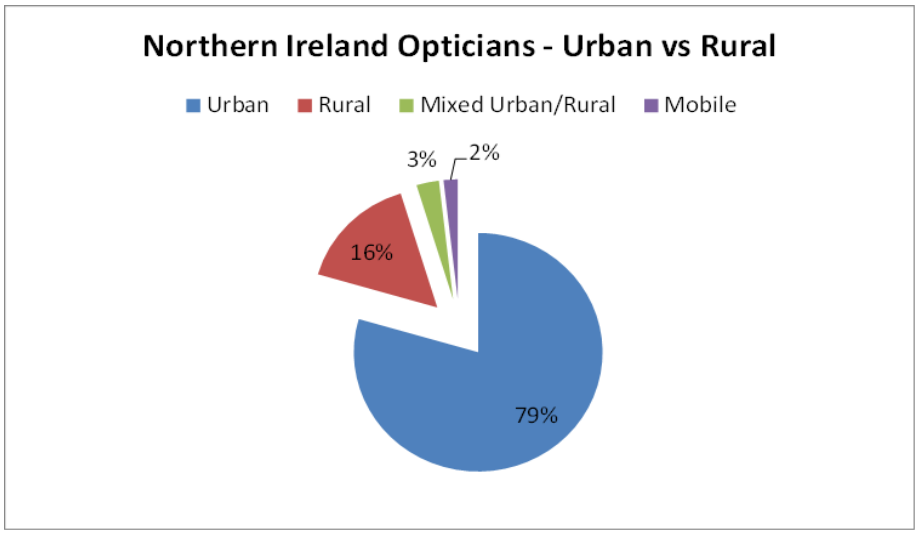
Analysis of the location of Northern Ireland Opticians by SOA (Super Output Area)[6] shows that the vast majority of opticians are based in urban areas. If this model is chosen this may adversely affect those living in rural areas compared to urban. This may be further exacerbated given that rural

[6] Based on location of Opticians as of June 2017, Business Services Organisations

practices are more likely to be small, single handed and have less capacity to provide an additional service such as screening.

The continued issues within primary care should also be considered, in particular the difficulties faced by smaller, single handed and rural practices. In 2016 the British Medical Association estimated that the majority of practices in rural areas are at risk of closure, with 3 out of 4 practices in Fermanagh at risk[7].

Figure 7 – Urban/Rural Split of NI Opticians



If the response to Section 3A was YES GO TO Section 4A.

3E. Please explain why no steps were taken by the PHA to identify the social and economic needs of people in rural areas?

N/A

[7] General Practice in Crisis – a report on Primary Care in Northern Ireland, BMA 2016

SECTION 4 - Considering the Social and Economic Needs of Persons in Rural Areas

4A. Please provide details of the issues considered in relation to the social and economic needs of people in rural areas.

Below are the key points which are currently being considered by the programme, in light of the information detailed in section 3D and the responses received during the pre-consultation.

Transport

Whilst the number of households without access to a car is higher in urban areas, the impact of sites which are inaccessible by public transport may be more significant in rural areas where the distance to travel is likely to be greater.

The provision of public transport in rural areas of Northern Ireland is a longstanding issue that is also influenced by the dispersed nature of the population in rural areas of Northern Ireland.

Age

The definition of the eligible population for Diabetic Eye Screening is unusual amongst screening programmes in that it is wide ranging in relation to age with no upper age limit, e.g. there are 5,186 people living with diabetes over the age of 85 in Northern Ireland[8]. This aging population is particularly important as it is reported that Type 2 diabetes is more likely to be diagnosed over the age of 40, and that the general population is also living longer. The issues around accessibility for those who are reliant on carers, family or are living in nursing homes or assisted living should be taken into consideration when deciding on suitability of models and eventual screening sites. The availability of public transport to attend screening appointments is also important particularly for those in older age groups who are less likely to have access to private transport.

In relation to younger people invited to attend DESP, this group have particular needs with regard to their engagement with healthcare and historically have had a low uptake within the programme. Ongoing pilots, which combine eye screening with other diabetes checks within a transition clinic setting, have had positive impact. In respect of younger people's participation sites which could offer appointments outside normal working hours would be of benefit to those who are of working age and/or within education.

Health

As outlined above there are higher rates of disabilities amongst those living with diabetes, along with increased rates of comorbidities. In 2015/16 76% of those living with diabetes also suffered with co-morbidities such as asthma, coronary heart disease, hypertension or stroke. Those with some disabilities are also at increased risk of developing diabetes,

[8] Health and Social Care Board. Clinical Informatics Team. Primary Care Data Extract 2015/16.

including those with learning disabilities (estimated at twice the prevalence of general population[9]), depression, schizophrenia, and those who have had a stroke or heart attack. Therefore there will be increased and more complex needs in terms of accessibility, flexibility of appointment (date, time and location).

Dependent Status

Those with dependents/caring responsibilities may be affected by the removal of screening from most GP practices, however conversely they may find the introduction of fixed sites or high street optometry advantageous, in that they will no longer be restricted to their practices, within a tight time period and within surgery opening hours.

The impact of a change to the model to fixed sites or high street optometry may be higher on those in rural areas, with the added complication of travel distance/time.

Availability of Services

Whilst it is not possible to analyse the availability of potential fixed sites in rural areas, the majority of HSC health and wellbeing centres and community hospitals will be in larger settlement areas and are unlikely to be in rural areas and small settlements. A more detailed analysis of impact cannot be carried out until possible fixed sites/high street optometrists locations are scoped.

[9] Diabetes UK. Improving care for people with diabetes and a learning disability, 2018. Available at: https://www.diabetes.org.uk/resources-s3/2018-02/Improving%20care%20for%20peeople%20with%20diabetes%20and%20a%20learning%20disability%20-%20Fact%20sheet%201.pdf

SECTION 5 - Influencing the Policy, Strategy, Plan or Public Service

5A. Has the development, adoption, implementation or revising of the Policy, Strategy or Plan, or the design or delivery of the Public Service, been influenced by the rural needs identified?

Yes ☐ **No** ☐ **If the response is NO GO TO Section 5C.**

5B. Please explain how the development, adoption, implementation or revising of the Policy, Strategy or Plan, or the design or delivery of the Public Service, has been influenced by the rural needs identified.

It is recognised that accessibility of sites will need to be considered to ensure that travel to sites is minimised and that public transport links are optimised. However given that a model for service delivery has not yet been chosen, it is difficult to state the exact impact.

If the response to Section 5A was YES GO TO Section 6A.

5C. Please explain why the development, adoption, implementation or revising of the Policy, Strategy or Plan, or the design or the delivery of the Public Service, has NOT been influenced by the rural needs identified.

N/A

SECTION 6 - Documenting and Recording

6A. Please tick below to confirm that the RNIA Template will be retained by the PHA and relevant information on the Section 1 activity compiled in accordance with paragraph 6.7 of the guidance.

I confirm that the RNIA Template will be retained and relevant information compiled. ☐

Rural Needs Impact Assessment undertaken by:	Claire Armstrong
Grade:	**7**
Directorate:	**Service Development & Screening**
Signature:	
Date:	
Rural Needs Impact Assessment approved by:	
Grade:	
Directorate:	
Signature:	
Date:	

References

- Rohini Mathur et al. Diabetic Eye Disease: A UK Incidence and Prevalence Study. Royal National Institute for the Blind, 2017. Available at: https://www.rnib.org.uk/who-we-are-knowledge-and-research-hub-research-reports-prevention-sight-loss/dr-prevalence
- NHS Diabetic Eye Screening Programme. DES Standards and Performance Objectives. Updated April 2017. Public Health England. Available at: https://www.gov.uk/government/publications/diabetic-eye-screening-standards-and-performance-objectives
- Northern Ireland Diabetic Eye Screening Programme. Annual Report 2016/17. Public Health Agency and Belfast HSC Trust, 2018.
- Public Health Agency, Belfast HSC Trust. Investment Proposal Template for the Introduction of Surveillance Clinics, 2018.
- Health and Social Care Board, Clinical Informatics Team. Primary Care Data Extract 2015/16
- Northern Ireland Statistics and Research Agency. 2016 Mid-year Population Estimates, 2017. Available at: https://www.nisra.gov.uk/publications/2016-mid-year-population-estimates-northern-ireland
- Diabetes UK. Facts and Stats 2016. Available at: https://www.diabetes.org.uk/Documents/Position%20statements/DiabetesUK_Facts_Stats_Oct16.pdf
- Diabetes UK. Transition: Diabetes UK position on the transition of a young person from Paediatric Care into Adult Care, February 2017.
- Department for Infrastructure. Travel Survey for Northern Ireland (TSNI) urban-rural report 2014-2016, 2018. Available at: https://www.infrastructure-ni.gov.uk/publications/travel-survey-northern-ireland-tsni-urban-rural-report-2014-2016
- Public Health England. Diabetes prevalence estimates for local populations, 2015. Available at: https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations
- Northern Ireland Statistics and Research Agency. Mid-year Population Estimates 2016 at Small Area Level. November 2017.
- Department of Agriculture, Environment and Rural Affairs. A Guide to the Rural Needs Act(NI) 2016 for Public Authorities (Revised April 2018)

- Northern Ireland Statistics and Research Agency. Northern Ireland Census 2011, Table 405
- Northern Ireland Assembly, Research and information Service Research Paper, Key Statistics for Settlements, Census 2011, Oct 2015, Dr Raymond Russell
- Northern Ireland Assembly, Research and Library Service Briefing Paper. Key Health Issues affecting Rural Communities. September 2010
- Office for National Statistics, Tim Pateman. Rural and urban areas: comparing lives using rural/urban classifications 2010/11.
- Department of Health. Making Life Better – Key Indicators Progress Update Tables 2018.
- Northern Ireland Statistics and Research Agency. Continuous Household Survey 2016/17
- Business Services Organisation. Family Practitioner Services, Ophthalmic Practice List June 2017.
- British Medical Association. General Practice in Crisis – a report on primary care in Northern Ireland. 2016.
- Diabetes UK. Improving care for people with diabetes and a learning disability, 2018. Available at: https://www.diabetes.org.uk/resources-s3/201802/Improving%20care%20for%20peeople%20with%20diabetes%20and%20a%20learning%20disability%20-%20Fact%20sheet%201.pdf